STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041072	A. BUILDING: _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON OAKS	3004 DEXTER AVENUE GREENSBORO, NC 27407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on May 1, 2019; with an exit via telephone conference on May 2, 2019.	D 000	Responses to cited deficiencies do not constitute an admission or agreement of the facility. The truth of the facts alleged or conclusion set forth in the statement of Deficiency or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing licensed practitioner for 1 of 5 sampled residents (Resident #5) with orders for a statin, a hormone, a beta blocker, and a bronchodilator. The findings are: Review of Resident #5's current FL2 dated 10/22/18 revealed diagnosis of Alzheimer's disease, chronic obstructive pulmonary disease,	D 358	The memory care manager will complete a cart audit for all current residents to ensure all ordered medications are available for administration. MAs will receive in-service training regarding weekly cart audits and re-ordering medication in a timely manner. Documentation of training provided will be maintained in the community for review. Cart Audits will be completed weekly for all residents and medications re-ordered in a timely manner. The ED and Care Managers will be responsible for weekly monitoring to ensure ongoing compliance.	06/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dr. Dr R. Barnes — TITLE: Executive Director — (X6) DATE: 10.29.19

Reviewed and accepted. AJS 06/28/19

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D 358	Continued From page 1 hypertension, pulmonary nodules, bipolar disorder, anemia, atrial fibrillation, and schizophrenia.	D 358		
	a. Review of Resident #5's current FL2 dated 10/22/18 revealed an order for atorvastatin (a medication used to treat high blood pressure) 40 mg every evening. Review of Resident #5's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for atorvastatin 40 mg every evening scheduled at 8:00 pm. -Staff documented atorvastatin was not administered because the medication was not available to be administered for 10 of 31 opportunities from 03/13/19-03/16/19 and from 03/18/19-03/23/19. Observation of Resident #5's medications on hand on 05/01/19 at 5:56 pm revealed: -Atorvastatin 40 mg was available to be administered. -There were 30 tablets of atorvastatin dispensed on 04/20/19. -There were 23 tablets remaining. Interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am revealed: -Atorvastatin was an active order. -There were 30 tablets last dispensed on 01/14/19. -There were 30 tablets last dispensed on 03/24/19. -There were 30 tablets last dispensed on 04/20/19. -Atorvastatin was on a cycle fill. -They did not dispense atorvastatin in February 2019 because the prescription had expired.			

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D 358	Continued From page 2 Interview with a first shift MA on 05/02/19 at 10:35 am revealed: -She did not know when the last cart audit was completed for Resident #5. -She did not remember Resident #5 being without atorvastatin. Interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm revealed: -They did not remember having an issue with the prescription for atorvastatin in March 2019. -They did not know Resident #5 missed 10 doses of atorvastatin. -A cart audit was completed on 03/05/19 and staff documented 7 tablets of atorvastatin were available. -A cart audit was completed on 03/19/19 and staff documented 0 tablets of atorvastatin were available. -The atorvastatin should have been ordered prior to running out. Interview with the Executive Director on 05/02/19 at 10:19 am revealed she did not know there were 10 occasions in March 2019 when the atorvastatin was not administered as ordered due to the medication not being available. Interview with the primary care provider (PCP) on 05/02/19 at 11:20 am revealed: -She did not know Resident #5 missed 10 doses of atorvastatin in March 2019. -Resident #5 was prescribed atorvastatin to manage high cholesterol. -She was not concerned Resident #5 missed 10 doses of atorvastatin in March 2019. -She expected staff to notify her when a medication is not administered as ordered.	D 358		

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D 358	Continued From page 3 Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Refer to the interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am. Refer to the interview with a third shift Medication Aide (MA) on 05/02/19 at 10:09 am. Refer to interview with a first shift MA on 05/02/19 at 10:35 am. Refer to interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm. Refer to interview with the Executive Director on 05/02/19 at 10:19 am revealed: Refer to interview with the primary care provider (PCP) on 05/02/19 at 11:20 am. b. Review of Resident #5's subsequent order dated 11/15/18 revealed an order for melatonin (a medication used for sleep) 5 mg at bedtime. Review of Resident #5's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 5 mg every evening scheduled at 8:00 pm. -Staff documented melatonin was not administered because the medication was not available to be administered for 6 of 31 opportunities from 03/01/19-03/06/19. Observation of Resident #5's medications on hand on 05/01/19 at 5:56 pm revealed:	D 358		

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D 358	Continued From page 4 -Melatonin 5 mg was available to be administered. -There were 30 tablets of melatonin dispensed on 03/30/19. -There were 2 tablets available from the melatonin dispensed on 03/30/19. -There were 30 tablets of melatonin dispensed on 04/28/19. -There were 30 tablets available from the melatonin dispensed on 04/28/19. Interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am revealed: -Melatonin 5 mg was an active order. -There were 30 tablets of melatonin dispensed on 03/30/19. -There were 30 tablets of melatonin dispensed on 04/28/19. -Melatonin was on a cycle fill. Interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm revealed: -They did not know melatonin was not administered for 6 of 31 days in March 2019. -A cart audit was completed on 03/05/19 and staff documented 30 tablets of melatonin were available. -A cart audit was completed on 03/19/19 and staff documented 17 tablets of melatonin were available. Interview with the Executive Director on 05/02/19 at 10:19 am revealed she did not know there were 6 occasions in March 2019 when the melatonin was not administered as ordered due to the medication not being available. Interview with the primary care provider (PCP) on 05/02/19 at 11:20 am revealed:	D 358		

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D 358	Continued From page 5 -She did not know Resident #5 missed 6 doses of melatonin in March 2019. -Resident #5 was prescribed melatonin for sleep. -She was not concerned Resident #5 missed 6 doses of melatonin in March 2019. -She expected staff to notify her when a medication is not administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Refer to the interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am. Refer to the interview with a third shift Medication Aide (MA) on 05/02/19 at 10:09 am. Refer to interview with a first shift MA on 05/02/19 at 10:35 am. Refer to interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm. Refer to interview with the Executive Director on 05/02/19 at 10:19 am revealed: Refer to interview with the primary care provider (PCP) on 05/02/19 at 11:20 am. c. Review of Resident #5's current FL dated 10/22/18 revealed an order for carvedilol (a medication used to treat high blood pressure) 6.25 mg twice a day with meals. Review of Resident #5's April 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carvedilol 6.25 mg twice	D 358		

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D 358	Continued From page 6 a day with meals scheduled at 8:00 am and 5:00 pm. -Staff documented carvedilol was not administered because the medication was not available to be administered for 4 of 60 opportunities from 04/13/19-04/15/19. -On 03/14/19 at 5:00 pm, staff documented they reordered the carvedilol because it was not available on the medication cart. Observation of Resident #5's medications on hand on 05/01/19 at 5:56 pm revealed: -Carvedilol 6.25 mg was available to be administered. -There were 60 tablets of carvedilol dispensed on 04/16/19. -There were 44 tablets remaining. Interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am revealed: -Carvedilol was an active order. -There were 60 tablets of carvedilol dispensed on 03/20/19. -There were 60 tablets of carvedilol dispensed on 04/16/19. -Carvedilol was on a cycle fill. Interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm revealed: -They did not know Resident #5 missed 4 doses of carvedilol because the medication was not available during April 2019. -A cart audit was completed on 03/05/19 and staff documented 35 tablets of carvedilol were available. -A cart audit was completed on 03/19/19 and staff documented 37 tablets of carvedilol were available.	D 358		

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D 358	Continued From page 7 Interview with the Executive Director on 05/02/19 at 10:19 am revealed she did not know there were 4 occasions in April 2019 when the carvedilol was not administered as ordered due to the medication not being available. Interview with the primary care provider (PCP) on 05/02/19 at 11:20 am revealed: -She did not know Resident #5 missed 4 doses of carvedilol in April 2019. -Resident #5 was prescribed carvedilol to manage high blood pressure. -She was not concerned Resident #5 missed 4 doses of carvedilol in March 2019. -She expected staff to notify her when a medication is not administered as ordered. -Missing doses of carvedilol could cause increased blood pressure, but Resident #5 had not experienced an increase in his blood pressure. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Refer to the interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am. Refer to the interview with a third shift Medication Aide (MA) on 05/02/19 at 10:09 am. Refer to interview with a first shift MA on 05/02/19 at 10:35 am. Refer to interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm. Refer to interview with the Executive Director on 05/02/19 at 10:19 am revealed:	D 358		

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D 358	Continued From page 8 Refer to interview with the primary care provider (PCP) on 05/02/19 at 11:20 am.	D 358		
	d. Review of Resident #5's current FL dated 4/19/17 revealed an order for ventolin (a medication used to treat chronic obstructive pulmonary disease) 90 mcg 2 puffs every 6 hours for shortness of breath or wheezing. Review of Resident #5's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for ventolin 90 mcg 2 puffs every 6 hours scheduled at 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm. -Staff documented ventolin was not administered because the medication was not available to be administered for 6 of 124 opportunities. -On 03/24/19 at 6:00 am and 12:13 pm, staff documented ventolin was not administered because the medication was not available to be administered. -On 03/25/19 at 12:00 am, 6:00 am, and 6:00 pm staff documented ventolin was not administered because the medication was not available to be administered. -On 03/26/19 at 12:00 am, staff documented ventolin was not administered because the medication was not available to be administered. Review of Resident #5's April 2019 eMAR revealed: -There was an entry for ventolin 90 mcg 2 puffs every 6 hours scheduled at 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm. -Staff documented ventolin was not administered because the medication was not available to be administered for 5 of 120 opportunities. -On 04/17/19 at 12:00 am, 6:00 am, and 6:00 pm			

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D 358	Continued From page 9 staff documented ventolin was not administered because the medication was not available to be administered. -On 04/17/19 at 6:00 pm, staff documented the facility was waiting on the pharmacy. -On 04/18/19 at 12:00 am and 6:00 am staff documented ventolin was not administered because the medication was not available to be administered. -On 04/18/19 at 12:00 am, staff documented the facility was waiting on the pharmacy. Observation of Resident #5's medications on hand on 05/01/19 at 5:56 pm revealed: -Ventolin 90 mcg was available to be administered. -There was 1 ventolin inhaler dispensed on 04/16/19. Interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am revealed: -Ventolin was an active order. -There was 1 ventolin inhaler dispensed on 02/25/19. -There was 1 ventolin inhaler dispensed on 03/24/19. -There was 1 ventolin inhaler dispensed on 04/16/19. -Each inhaler should last for 25 days. -Ventolin was not on a cycle fill. Interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm revealed: -They did not know Resident #5 missed 5 doses of ventolin because the medication was not available during April 2019. -A cart audit was completed on 03/05/19 and staff documented 1 ventolin inhaler was available. -A cart audit was completed on 03/19/19 and staff	D 358		

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D 358	Continued From page 10 documented 1 ventolin inhaler was available. Interview with the Executive Director on 05/02/19 at 10:19 am revealed she did not know there were 4 occasions in April 2019 when the carvedilol was not administered as ordered due to the medication not being available. Interview with the primary care provider (PCP) on 05/02/19 at 11:20 am revealed: -She did not know Resident #5 missed 6 doses in March 2019 and 5 doses of ventolin in April 2019. -Resident #5 was prescribed ventolin to manage COPD. -She was not concerned Resident #5 missed doses of ventolin in March 2019 and April 2019. -Missing doses of ventolin could cause increased shortness of breath. -She expected staff to notify her when a medication is not administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Refer to the interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am. Refer to the interview with a third shift Medication Aide (MA) on 05/02/19 at 10:09 am. Refer to interview with a first shift MA on 05/02/19 at 10:35 am. Refer to interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm. Refer to interview with the Executive Director on 05/02/19 at 10:19 am revealed:	D 358		

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D 358	Continued From page 11 Refer to interview with the primary care provider (PCP) on 05/02/19 at 11:20 am. Interview with the facility's contracted pharmacy on 05/02/19 at 10:46 am revealed: -Not all medications were on a cycle fill. -The goal was to refill medications several days prior to the medication running out so the resident was not without medication. Interview with a third shift Medication Aide (MA) on 05/02/19 at 10:09 am revealed: -When staff documented medications/items not available on the eMAR this would mean the facility was waiting on the pharmacy. -The MA was responsible for contacting the pharmacy for refills. -The MAs were responsible for conducting cart audits Monday through Saturday. -During the cart audits the MA would pull out every medication for a list of residents and account for each medication. -By the end of the week every residents medications have been counted and MAs should have notified the pharmacy if a refill was needed. -If there was an issue filling the medication the MAs would communicate the issue with the RCC/MCC. -They thought the MA did not contact the pharmacy for a refills. Interview with a first shift MA on 05/02/19 at 10:35 am revealed: -MAs had a list of residents each day to complete cart audits. -She was not sure when the last cart audit was completed for Resident #5. -During the cart audit the MA was to make sure the ordered medication was on the cart and order	D 358		

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D 358	Continued From page 12 any medications that are low. Interview with the Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) on 05/01/19 at 6:13 pm revealed: -MAs conduct cart audits daily according to a schedule. -MAs counted each medication on the cart for each resident to ensure the resident did not run out of medication. -MAs were responsible for contacting the pharmacy regarding refills. -The MAs would communicate any difficulties refilling a medication with the RCC/MCC. -The MA did not communicate any issues with refilling medications for Resident #5. Interview with the Executive Director on 05/02/19 at 10:19 am revealed: -The MAs were responsible for completing cart audits everyday. -The MAs should notify the pharmacy when there is a 7 day supply left to ensure the resident was not without the medication. Interview with the primary care provider (PCP) on 05/02/19 at 11:20 am revealed: -Resident #5 was last seen the last week of April 2019. -She expected staff to administer medications as ordered. -She expected staff to make her aware if a medication was not available and if the resident missed doses.	D 358		